

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *P.D.*

## CERTIFICATE OF DEATH

01718

Reg. Dist. No. 1880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Harford*  
 County: *Havre de Grace*  
 City or town: *(If outside city or town limits, write RURAL and give nearest town)*  
 How long in above place of death? *70 yrs*  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: *Md.* County: *Harford*  
 City or town: *Havre de Grace* (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war: *—*

3. (a) FULL NAME *Annie Wilde Anderson*  
 4. Sex: *Female* 5. Color or race: *white* 6. (a) Single, married, widowed, or divorced: *widowed*  
 6. (b) Name of husband or wife: *Wm. J. Anderson*  
 7. Birth date of deceased (mo., day, yr.) *Oct. 3, 1869* 6. (c) If alive, give age: *—* years  
 8. AGE: Years: *77* Months: *4* Days: *—* If less than one day: *—* hrs: *—* min: *—*  
 9. Birthplace: *Cecil Co. Md.* (Town, county, and state)  
 10. Usual occupation: *House Duties*  
 11. Industry or business: *Geo. C. McGill*  
 MOTHER FATHER  
 12. Name: *Geo. C. McGill*  
 13. Birthplace: *Ireland*  
 14. Maiden name: *Emma Rudy*  
 15. Birthplace: *Md.*  
 16. Informant: *Richard S. Campbell*  
 Address: *348 S. Morris St. Bumbyne Fd.*  
 17. Burial: *Burial* Date thereof: *Feb. 6 1947* (month) (day) (year)  
 Cemetery or crematory: *Angel Hill*  
 Location: *Havre de Grace Md.*  
 18. Funeral director: *R. Madison Mitchell*  
 Address: *Havre de Grace, Md.*  
 19. A. *Feb. 5 - 1947* (Date rec'd by registrar) B. *A. L. Lewis M.D.* (Signature)  
 Registrar

3. (b) Social Security Number: *—*

MEDICAL CERTIFICATION

20. DATE OF DEATH: *Feb. 3* 19. 47, at *4:50 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan. 28 1947* to *Feb. 3 1947* and that I last saw her alive on *Feb. 3 1947*.

Immediate cause of death: *Coronary occlusion*

Due to: *Chronic myocarditis*

Due to: *Cardiac decompensation*

Other conditions: *—*

(Include pregnancy within 3 months of death)

Major findings or operations: *—* Date of op.: *—*

Autopsy results: *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *—* Date of: *—*

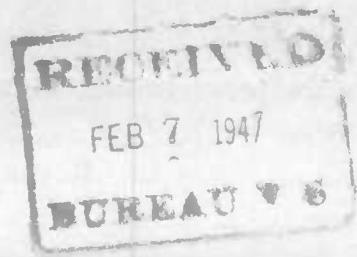
Where did injury occur? *—* (City or town) *—* (County) *—* (State) *—*

Injured at home, farm, industry, public place (where?) *—*

Means of injury: *—* Injured at work? *—*

23. SIGNATURE: *O. Lewis Jr.* M. D. or other: *—*

Date signed: *Feb. 5-47*



1-35-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01719

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Harford  
 County: Havre de Grace  
 City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? \_\_\_\_\_  
 Hospital, Institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: Md. County: Harford  
 City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: 311 Bourbon St (If rural, give LOCATION)

2.(a) Is veteran, name war: \_\_\_\_\_

3. (a) FULL NAME Harford Baldwin

3. (b) Social Security Number \_\_\_\_\_

4. Sex: Male 5. Color or race: white 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Elzie Way Baldwin

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1888 6.(c) If alive, give age: \_\_\_\_\_ years

8. AGE: Years: 58 Months: 3 Days: 34 If less than one day: \_\_\_\_\_ hrs: \_\_\_\_\_ min: \_\_\_\_\_

9. Birthplace: Havre de Grace Md. (Town, county, and state)

10. Usual occupation: Superintendent of Maintenance

11. Industry or business: Havre de Grace Water Co.

12. Name: Monroe P. Baldwin

13. Birthplace: Md.

MOTHER FATHER 14. Maiden name: P. May Fields

15. Birthplace: Md.

16. Informant: Miss Reta P. Way

Address: Havre de Grace, Md.

Burial: Burial Date thereof: Feb. 8, 1947 (month) (day) (year)

(Burial, cremation, or removal, Which?) Cemetery or crematory: Angel Dell

Location: Havre de Grace Md.

18. Funeral director: A. Madison Mitchell

Address: Havre de Grace, Md.

19. Feb. 8 19 47 R.S. Lewis M.D. (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5 1947 at 11<sup>40</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5 1947 to Feb. 5 1947 and that I last saw h. in alive as Feb. 5 1947

Immediate cause of death: Arturia Stevens DURATION

Due to: Coronary Thrombosis

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings or operations: \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury: \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles J. Foley M.D. M. D. or other

Date signed: 2/7/47

Address: Havre de Grace, Md.

RECEIVED

FEB 10 1947

BUREAU F.B.I.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

01720

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-0

## 1. PLACE OF DEATH:

County.....

Harford

City or town.....

Harpers Ferry

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 13 days

Hospital, Institution, or street address where death occurred:

Harford Mem Hosp

How long in hospital or institution?..... 13 days

## 3. (a) FULL NAME

Charles Brooks

4. Sex

M

5. Color or race

C

6.(a) Single, married, widowed, or divorced

M

6.(b) Name of husband or wife.....

Ella Brooks

7. Birth date of deceased (mo., day, yr.)

Dec 25 1882

8. AGE: Years

64

Months

1

Days

If less than one day

hrs.

min.

9. Birthplace.....

Darlington Md

(Town, county, and state)

10. Usual occupation.....

House Duties &amp; Store Help

11. Industry or business

Charles H Brooks

MOTHER FATHER

12. Name.....

Ella

Brooks

Md

13. Birthplace.....

Beach Bond

Md

14. Maiden name.....

Churchville

Md

15. Birthplace.....

Mrs Ella Brooks

Bel Air Md

Md

16. Informant.....

Burial

Date thereof.....

Feb 16 1947

(Burial, cremation, or removal. Which?)

(monthly) (day) (year)

Cemetery or crematory.....

Asbury

Location.....

Near Churchville, Md

Md

18. Funeral director.....

Dean T Futter

Address.....

Bel Air Md

Md

19. Date rec'd by registrar.....

Feb 13 1947

(Date rec'd by registrar)

A. L. Lewis M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Harford

City or town.....

Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 13

1947 at 7:54 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1 1947 to Feb 13 1947

and that I last saw h.s. alive on Feb 13 1947

Immediate cause of death.....

Congestive heart failure

Due to.....

Arteriosclerosis CV disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Autopsy results.....  
Pulm Edema & Ch. nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

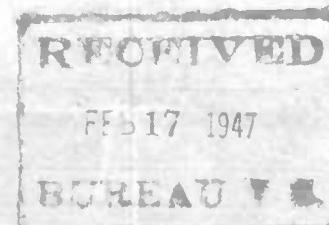
Dudley Shibley Md  
Harford Mem Hosp Date signed 2/13/47

M. D. or other

RECEIVED TO TRANSLATE STATE CHARTER

RECEIVED TO TRANSLATE

RECEIVED TO



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

## CERTIFICATE OF DEATH

01721, 185-0  
Reg. Dist. No. ....

121

1. PLACE OF DEATH:  
 County Harford  
 City or town Havre de Grace (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where deceased resided Harford Mem Hosp  
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md County Harford  
 City or town Havre de Grace (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war. \_\_\_\_\_

3. (a) FULL NAME  
Herman L Bushman

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife Rink

7. Birth date of deceased (mo., day, yr.) unk. 6.(c) If alive, give age ..... years

8. AGE: Years 83 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace ? (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Rink

MOTHER 13. Birthplace unk.

14. Maiden name ?

15. Birthplace

16. Informant Harford Memorial Hospital

Burial Address Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Angel Hill Date thereof Mar. 1 1947 (month) (day) (year)

Cemetery or crematory Havre de Grace Md.

Location R. Madison Hatchell

18. Funeral director Havre de Grace Md.

Address Feb. 28 1947

19. (Date rec'd by registrar) A. L. Lewis Jr.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 19.47 et 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/23 19.47 to 2/25 19.47 and that I last saw him alive on 2/25 19.47

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Congestive Heart Failure 2-3 yr.

Due to Arterialclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Severe Effusion - Esoph - enterocolon Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

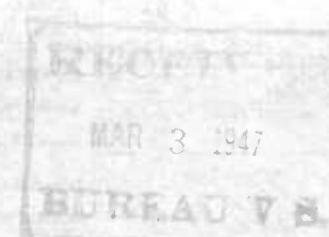
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Quella Shelly M.D. M. D. or other \_\_\_\_\_

Address Harford Mem Hosp Date signed 3/26/47

RELAYED TO THE STATE DEPARTMENT

RELAYED TO STAGHORN



1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 710

01722

## CERTIFICATE OF DEATH

Reg. Dist. No. 1860

1. PLACE OF DEATH: Harford  
 County: Rural - Hare de Grace  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? About 23 yrs.  
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Edward H. Chalk

4. Sex	5. Color or race	6. (d) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Robert P. Hallion7. Birth date of deceased (mo., day, yr.) Sept. 7, 1888 60 years8. AGE: Years 58 Months 5 Days  If less than one day  hrs.  min. 9. Birthplace Waterail Harford Co., Md.  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Thomas H. Chalk12. Name Thomas H. Chalk13. Birthplace Harford Co., Md.14. Maiden name Della E. Carter15. Birthplace Harford Co., Md.16. Informant Mrs. Roberta G. ChalkAddress Hare de Grace - P. O. D.17. Burial Burial Date thereof Sept. 22, 1947  
(Burial, cremation, or removal. When?) (month) (day) (year)Cemetery or crematory Rock RunLocation Near Darlington, Md.18. Funeral director Henry Talcott & SonsAddress 1 Berdeau, Md.19. Feb. 21, 1948 a. d. Lewis no. 11414  
(Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County Harford  
City or town Rural - Hare de Grace, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. None  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number 212-26-9739

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-47 1947 at 10:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1944 to 2-18-47 1947  
and that I last saw him alive on 2-18-47 1947Immediate cause of death Constrictive pericarditis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

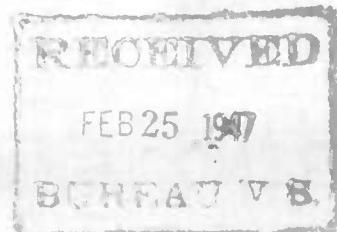
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE A. L. Lewis M. D. or other Dr. Harry S. LewisAddress Hare de Grace, Md. Date signed 2-21-48



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

21723

## CERTIFICATE OF DEATH

Reg. Dist. No.

1858

## 1. PLACE OF DEATH:

County

Harford County

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

None

## 3. (a) FULL NAME

Katherine P. Clark

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Harfield Scott Clark

7. Birth date of deceased (mo., day, yr.)

Dec 29th 1908

6. (c) If alive, give age

44

years

8. AGE:

38

Years

1

Months

17

Days

17

If less than one day

hrs. 1 min.

9. Birthplace

Baltimore

Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Harold W. Ryan

FATHER

13. Birthplace

Talbot County

MD

14. Maiden name

Mary Katherine Smith

MOTHER

15. Birthplace

Harford County

MD

Harfield Scott Clark

16. Informant

Address

Tallstar

Md

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Location

Edmonson Ave

Baltimore

18. Funeral director

George J. Roth Jr.

Address

1735 Harford Ave

19. (Date rec'd by registrar)

2-17-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7401

## CERTIFICATE OF DEATH

01724  
182

Reg. Dist. No.

1. PLACE OF DEATH: Harford Forest Home Md R.R.  
 County: Harford  
 City or town: Forest Home (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John H. Davis

4. Sex Male 5. Color of face White 6. (a) Single, married, widowed, or divorced Widower

Male White Widower

6. (b) Name of husband or wife Dead 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1865

8. AGE: Years 81 Months 10 Days 19 It less than one day hrs. min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Housework

12. Name Engel H. Davis

13. Birthplace Chester Co., Penna

14. Maiden name Elizabeth Amos

15. Birthplace Harford Co., Md.

16. Informant Mr. Stanley Davis

Address Forest Home Md.

17. Burial Burial Date thereof Feb. 25, 1947 (Burial, cremation) (month) (day) (year)

Cemetery Union Chapel Cem

Location Harford Co., Md.

18. Funeral director H. S. Bailey

Address Arlington Md.

19. 2/24/47 19 1947 Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Md County Harford

City or town Forest Hill (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1947 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Feb 22 1947

and that I last saw him alive on Feb 18 1947

Immediate cause of death Chr. Lymphatic Leukemia

DURATION ?

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations: \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

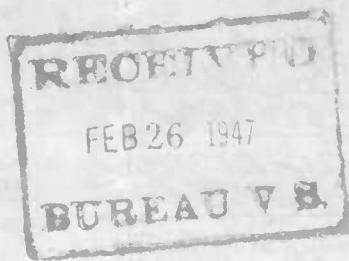
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Willard P. Hudson M. D. or other \_\_\_\_\_

Date signed 2/22/47

Address Forest Hill Md.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
year of birth shown  
on Film G.109 - 3/24/47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1947

01725

## CERTIFICATE OF DEATH

Reg. Dist. No. 1821

## 1. PLACE OF DEATH:

County.....

Harford  
Chestnut Hill

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

70 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Howard Towood

## 3. (b) Social Security Number

Mr

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single  
None

6. (b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Jan. 24, 1877

8. AGE:

Years

Months

Days

If less than one day

70

0

105

hrs.

min.

9. Birthplace.....

Harford Co. Md.

(Town, county, and state)

10. Usual occupation.....

Garrison

11. Industry or business

Crop

12. Name.....

Parker Towood

13. Birthplace.....

Harford Co. Md.

14. Maiden name.....

Julia Morrison

15. Birthplace.....

Harford Co. Md.

16. Informant.....

Mr. Morris Towood

17. Burial.....

Street, Md. &amp; R. H.

Address.....

Burial

Date thereof (month) (day) (year)

Cemetery or crematory.....

Dear Crem Cem

Location.....

Chestnut Hill, Harford Co.

18. Funeral director.....

T. S. Bailey

Address.....

Arlington Md.

19. (Date rec'd by registrar)

Feb. 10, 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Harford

City or town.....

Rural Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Chestnut Hill

Mr

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 9<sup>th</sup> 1947 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 9<sup>th</sup>, 1947, to Feb. 9<sup>th</sup>, 1947,

and that I last saw her.....alive on

Immediate cause of death.....

Coronary Thrombosis DURATION 20 min

Due to.....

Due to.....

Other conditions Ch myocardial disease?

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

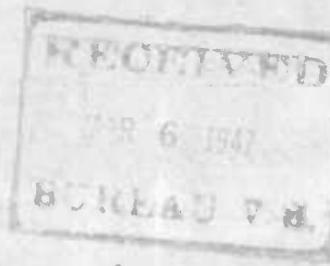
Injured at work?

23. SIGNATURE.....

Willard P. Anderson M. D. or other

Address.....

Forest Hill Md. Date signed 2/10/47



2-25

2-1820 — 2-10

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

01726

## CERTIFICATE OF DEATH

Reg. Dist. No. 1821

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Harford*  
County: *Harford*

City or town: *Huber* (If outside city or town limits, write RURAL and give nearest town) *89*

How long in above place of death? *89*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Charles A. Griffith*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife *None*

7. Birth date of deceased (mo., day, yr.) *May 18, 1867* 6. (c) If alive, give age years

8. AGE: Years *79* Months *8* Days *21* If less than one day

hrs. min.

9. Birthplace *Harford Co., Md.* (town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business *Crop*

FATHER 12. Name *Amar Griffith*

MOTHER 13. Birthplace *Harford Co., Md.*

14. Maiden name *Unknown*

15. Birthplace

16. Informant *Mr. Alfred Griffith*

Address *Bil-Air, Md. R.R.*

Burial Date thereof *Fe. 11, 1947*

(Burial, cremation, or removal. Which?)

Cemetery or crematory *Public Cem*

Location *Harford Co., Md.*

18. Funeral director *H. D. Bailey*

Address *Darlington, Md.*

19. Date rec'd by registrar *Feb. 18, 1947*

(Date rec'd by registrar) *W.H. Kirk*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Harford*

City or town *Huber* (If outside city or town limits, write RURAL and give nearest town)

Street No. *No* (If rural, give LOCATION)

2.(a) If veteran, name war *No*

3. (b) Social Security Number *No*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *February 9* 1947 at 5.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4 1947 to February 9 1947

and that I last saw him alive on February 8 1947

Immediate cause of death *cerebral hemorrhage* DURATION

Due to *sclerosis of the arteries.*

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Barry Donegan* M.D. or other

Address *1000 Cardiffo* Date signed *2-10-47*



2-1820 — 2-10

PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-B

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

0172780

## 1. PLACE OF DEATH:

County.....

City or town.....

Harford  
Magnolia

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
45 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Kathryn L. Gunther

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

William L. Gunther

7. Birth date of deceased (mo., day, yr.)

Apr 25, 1876

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

70

9

26

hrs.

min.

9. Birthplace.....

Philadelphia Pa

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

FATHER

12. Name.....

John Henry Carroll

13. Birthplace.....

Essen, Germany

14. Maiden name.....

Elizabeth B. Rainbold

15. Birthplace.....

Fallston Maryland

16. Informant.....

William L. Gunther

Address.....

Magnolia Maryland

Burial

Date thereof.....  
(Burial, cremation, or removal. Which?)Feb. 24, 1947  
(month) (day) (year)

Cemetery or crematory.....

Oakbury

Location.....

Abingdon Maryland

18. Funeral director.....

Howard K. McCormick

Address.....

Abingdon Maryland

Feb 24,

1947

Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Harford

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 21

1947

ef. 7-20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 28, 1947, to Feb 21, 1947

and that I last saw him alive on Feb 21, 1947

Immediate cause of death.....

Chronic Glomerular nephritis

Chronic myocarditis

DURATION

5 yrs

years!

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Fred O Hodson M.D. M. D. or other

Edgewood, Md. Date signed 2-22-47

RECEIVED

FEB 26 1947

BUREAU V 8

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1950

01728

## CERTIFICATE OF DEATH

Reg. Dist. No. 1850

## 1. PLACE OF DEATH:

County

*Hayford*

City or town

*Hanover Grace*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *about 4 weeks.*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*William Earl Gughton*

4. Sex

*Male*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*Single*

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

*1/16/47*

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

28

hrs.

min.

9. Birthplace

*Hanover Grace, Md.*

(Town, county, and state)

10. Usual occupation

*none*

11. Industry or business

*Farland Gughton*

12. Name

MOTHER

FATHER

13. Birthplace

North Carolina

Rebelle Puckett

14. Maiden name

North Carolina

15. Birthplace

Rebelle Puckett

16. Informant

Mr. Farland Gughton

Address

Revolution &amp; Junata Sts

17. Burial

Cemetery or crematory

Angel Hill

Location

Hanover Grace

18. Funeral director

Huntington &amp; Co

Address

Hanover Grace, Md.

19. Date rec'd by registrar

1947

A. L. Lewis, M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

*Hayford*

City or town

*Hanover Grace*

Street No.

*Revolution & Junata*

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

*Feb. 12*

1947 at 6:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw h... alive on

19...

Immediate cause of death

*Accidental Asphyxiation*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

*None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

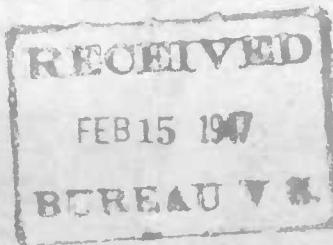
Accident, suicide, or homicide accident Date of 2/12/47Where did injury occur Hanover Grace (City or town) Hayford (County) Md. (State)Injured at home, farm, industry, public place (where?) HouseMeans of injury aspiration of vomitus Injured at work?

23. SIGNATURE

*Dr. Ramsey, M.D.*

Deputy Medical Examiner or other

Address Aberdeen, Md. Date signed 2/12/47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

01729

## CERTIFICATE OF DEATH

Reg. Dist. No. 18a

## 1. PLACE OF DEATH:

County HartfordCity or town Hickory Rural

(If outside city or town limits, write RURAL and give nearest town)

45 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced W6. (b) Name of husband or wife Kate E Herrman7. Birth date of deceased (mo., day, yr.) July 15-1861

6. (c) If alive, give age years

8. AGE: Years 85 Months 6 Days 8 If less than one day  
hrs. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Hartford Co, Md  
(Town, county, and state)10. Usual occupation Farmer

## 11. Industry or business

FATHER 12. Name Wm G Herrman13. Birthplace Baltimore, Md14. Maiden name Eliza Holland15. Birthplace Hartford Co, Md16. Informant Roland HamiltonAddress Bel Air, Md17. Burial Date thereof Feb 26/47  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Barker's CemeteryLocation Near Aberdeen, Md18. Funeral director Dean A FosterAddress Bel Air Md19. 2/24 (Day rec'd by registrar) 49 Rivella Towwoods Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty HartfordCity or town Hickory Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war. \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1947 a<sup>6</sup> 30<sup>m</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 15 1946 to Feb 23 1947and that I last saw him alive on Feb 21 1947

Immediate cause of death

Chronic myocarditis DURATION 2 yrsDue to vDue to vOther conditions Cirr. Scleros.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

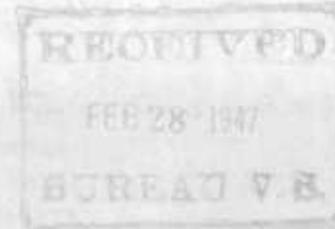
Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE E.P. Brodgrass

M. D. or other

Address Darlington BrdDate signed 2/24/47



1 -35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82

01730

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County Hartford

City or town Bel Air MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

George A Howard

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

Cub

Married

6. (b) Name of husband or wife Lillian Howard

7. Birth date of deceased (mo., day, yr.) June 11/1900

6. (c) If alive, give age 58 years

8. AGE: Years Months Days If less than one day  
46                     hrs.      min.

9. Birthplace Bel Air MD

(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Grant Howard

13. Birthplace MD

14. Maiden name Annie Rice

15. Birthplace MD

16. Informant Mrs. Lillian Howard

Address 411 W 28 St apt #30 New York (27)

17. Burial Date thereof July 11/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenwood Hill

Location Hartford Co. MD

18. Funeral director Grant Foster

Address Bel Air MD

19. (Date rec'd by registrar) 2/5/47 (Date of death) 4/7 (Name of deceased) Priscilla Howard

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford

City or town Bel Air MD

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war World War I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 47 at 2:40 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 20 1946 to Feb 5 1947

and that I last saw him alive on Feb 3 1947

Immediate cause of death

Chr myocardial Disease 1 yr

DURATION

Due to

Due to

Other conditions Posterior-lateral Sclerosis

29 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

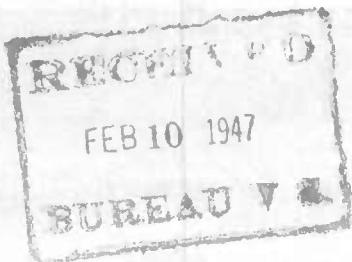
Means of injury

Injured at work?

23. SIGNATURE Willard P. Hudson

M. D. or other

Address Forest Hill 2nd Date signed 2/5/47



Z-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 190

01731

## CERTIFICATE OF DEATH

Reg. Dist. No. 1820

## 1. PLACE OF DEATH:

County HartfordCity or town Near High Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Hubert James4. Sex M5. Color or race W6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1900

8. AGE:

Years 46

Months

Days

If less than one day

hrs. .... min.

9. Birthplace Speedwell, Va.

(Town, county, and state)

10. Usual occupation Farm labor

## 11. Industry or business

12. Name Joe James

MOTHER FATHER

13. Birthplace Va14. Maiden name Florence James15. Birthplace Va16. Informant D B JamesAddress Forest H. II, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 15/47  
(month) (day) (year)Cemetery or crematory Groselose ChapelLocation Speedwell, Va18. Funeral director Dean Y FosterAddress Baltimore Md.19. 2/12 (Date rec'd by registrar)#9 Main Street (Street name and number)Registrar John L. Murphy

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty HartfordCity or town Near High Point (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

Feb. 12 1947 at 8:00 A.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Alcoholism  
Exposure to Cold

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

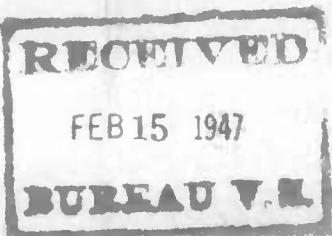
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

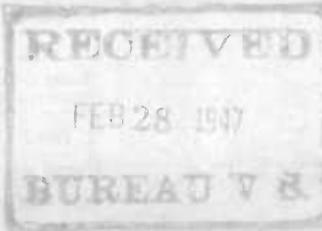
23. SIGNATURE

John Lawrence M.D.  
Deputy Medical Examiner  
Address Aberdeen, Md. Date signed 2/12/47



1-35





1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

Reg. Dist. No. 102  
01733

1. PLACE OF DEATH: Harford  
 County .....  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 35 years  
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State ..... Md County ..... Harford  
 City or town ..... Hallston  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

3. (a) FULL NAME William O. Lancaster

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Edmund Lancaster

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1882 8. (c) If alive, give age ..... years

8. AGE: Years 64 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_  
 hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation Farmer and Laborer

11. Industry or business Laborer

12. Name Willard Lancaster

MOTHER FATHER

13. Birthplace Maryland

14. Maiden name Julita Ward

15. Birthplace Maryland

16. Informant Mrs. Willard Lancaster

Address Hallston Md

17. Burial Cemetery or crematory Friendship  
 Location Hallston Md  
 18. Funeral director Oscar E. Gross  
 Address Benson Md

19. Date rec'd by registrar 2/6 47 Piscataway

3. (b) Social Security Number 214-169778

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1947 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1947, and that I last saw him alive on January 15 1947.

Immediate cause of death Paroxysm of bronchitis

Due to: — DURATION Week

Due to: —

Other conditions — Sudden

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results — PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

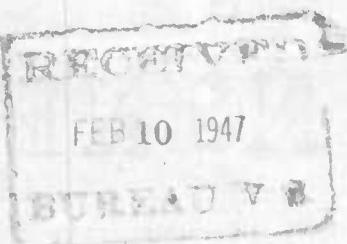
Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

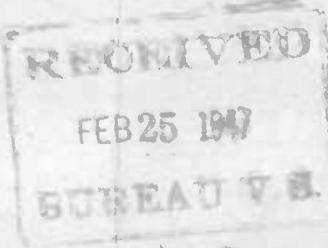
Means of injury — Injured at work? —

23. SIGNATURE W. Willard Slade M. D. or other —  
 Address Hallston Md Date signed 2/6/47



1-35





1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

01735

## CERTIFICATE OF DEATH

Reg. Dist. No. 1810

## 1. PLACE OF DEATH:

County.....

City or town.....

Harford  
Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution or street address where death occurred:

Phila Rd.

How long in hospital or institution?.....

## 3. (a) FULL NAME

WENDELL CHADMAN

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Mass.

County.....

Unknown

City or town.....

Unknown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

015-07-9150

## MEDICAL CERTIFICATION

Feb 14, 1947 19 at 7A. M

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

to

and that I last saw h. alive on

Immediate cause of death

Shock and Hemorrhage

DURATION

Due to: gunshot wound of head

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Suicide Date of 3/14/47

Where did injury occur? Aberdeen Harford Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) NoneMeans of injury .45 cal Revolver Injured at work? No

## 23. SIGNATURE

J. H. Launey M.D.

Deputy Medical Examiner

Address Aberdeen, Md. Date signed 3/15/47

4. Sex

Male White Married

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

Unknown

7. Birth date of deceased (mo., day, yr.)

Sept. 18, 1905

6.(c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

41

4

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Unknown

11. Industry or business

MOTHER FATHER

12. Name..... Stanley McDonald

13. Birthplace..... Fredericksburg, N.B.

14. Maiden name..... Ada Ross

15. Birthplace..... Brighton, N.B.

16. Informant..... Friend Circle certificate

Address

17. Burial Date thereof Feb. 18, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

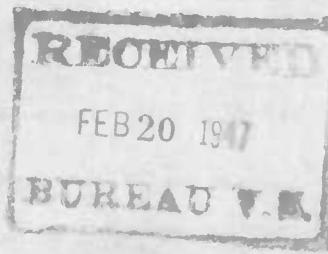
Cemetery or crematory..... Grove

Location..... Aberdeen, Md.

18. Funeral director..... Henry Tapping &amp; Sons

Address

19. Date rec'd by registrar Feb. 17, 1947 Nellie A. Riley  
(Date rec'd by registrar) Registrars



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 230

01736

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County.....

Harford

City or town.....

Jarrettsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

6 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Isabelle Bevold Ramley

## 3. (b) Social Security Number

4. Sex      5. Color or race      6.(a) Single, married, widowed, or divorced

Female white widow

6.(b) Name of husband or wife..... Robert N Ramley

7. Birth date of deceased (mo., day, yr.)..... Jan 18 1859

(6.c) If alive, give age..... years

8. AGE:      Years      Months      Days      If less than one day

88 1 7 hrs. min.

9. Birthplace..... Darlington Harford Co Md

(Town, county, and state)

10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... James Bevold

13. Birthplace..... Darlington Md

14. Maiden name..... Gemma Street

15. Birthplace..... Rocke Md

16. Informant..... Mrs J. L. Nelson

Address..... Jarrettsville Md.

17. Burial..... Burial Date thereof..... Feb 28-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Bethel

Location..... Madison Harford Co Md.

18. Funeral director..... Martin Gurtz

Address..... Jarrettsville Md.

19. Date rec'd by registrar..... Feb 28, 1947

(Date rec'd by registrar) Thomas R. Brown

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Harford

City or town..... Jarrettsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 25, 1947, at 9<sup>20</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1946, to Feb. 25, 1947

and that I last saw her alive on Feb. 24, 1947

Immediate cause of death..... Heart Failure

DURATION

8 hrs.

Due to..... Hypertensive cardio - vascular disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

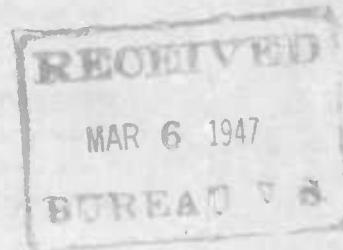
Means of injury.....

Injured at work?

23. SIGNATURE..... Charles A. Kell M.D.

M. D. or other

Address..... Street, Md. Date signed..... Feb. 27-47



2-33-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1100

11737

## CERTIFICATE OF DEATH

Reg. Dist. No. 1850

## 1. PLACE OF DEATH:

County.....

HARFORD

City or town.....

HAURE DE GRACE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 hours.

Hospital, institution, or street address where death occurred:

HARFORD MEMORIAL HOSPITAL

How long in hospital or institution?..... 6 hours.

## 3. (a) FULL NAME

VALLIE A. RUSSELL

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (c) Single, married, widowed, or divorced

Male White Married Mary Russell

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

58 7 23

hrs. .... min.

9. Birthplace.....

(Town, county, and state)

Harford Co., Md.

10. Usual occupation.....

Laborer

11. Industry or business.....

Old Farm

12. Name.....

MOTHER FATHER

Thomas Russell

13. Birthplace.....

Harford Co., Md.

14. Maiden name.....

Unknown

15. Birthplace.....

Mrs. Mary Russell

16. Informant.....

Haure de Grace Md. 10

Address

Burial

Date thereof Feb. 6, 1947

(Burial, cremation, or removal, if any)

(month) (day) (year)

Cemetery or crematory.....

Rock Run Cem

Location.....

Harford Co., Md.

18. Funeral director.....

Dr. D. Bailey

Address

Arlington Md.

19. Date rec'd by registrar

Feb. 5, 1947

(Date rec'd by registrar)

A. L. Lewis M.D.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD.

County..... HARFORD

City or town.....

ABERDEEN - RURAL

Street No.....

OLD Post Road - SWAN CREEK

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH

FEB. 3

1947 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

1. RUPTURED DUODENAL ULCER  
WITH FAT NECROSIS OF PERITONEAL  
CAVITY.

2. HEMATOOTHORAX - BILATERAL - SMALL

Doctor..... TRAUMATIC.

3. FRACTURE OF STERNUM - SIMPLE

Other conditions due to: automobile accident

cause

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of February 1st, 1947.

Where did injury occur? Aberdeen Harford Maryland

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?) Old Post Road &amp; Fenwick Street

Means of injury Automobile accident Injured at work?

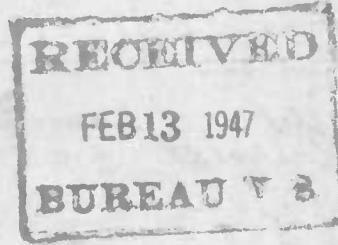
23. SIGNATURE.....

John Ramsey M.D.

Deputy Medical Examiner

Address..... Aberdeen, Md.

Date signed 2/14/47



2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 121

01738

## CERTIFICATE OF DEATH

Reg. Dist. No. 1850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH:

County..... Hanover  
 City or town..... Hanover (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 hours

Hospital, institution, or street address where death occurred: Hanford Mem. Hosp

How long in hospital or institution? 18 hours

## 3. (a) FULL NAME

Brian Allen Schweers

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife: —

7. Birth date of deceased (mo., day, yr.) July 11 - 1944 6. (c) If alive, give age years

8. AGE: Years 2 Months 7 Days 2 If less than one day hrs. min.

B. Birthplace Hanover (Town, county, and state) Md.

10. Usual occupation: Clerk

11. Industry or business: Wm. H. Schweers

12. Name of father: Wm. H. Schweers

13. Birthplace Lancaster Pa.

14. Maiden name: Clair Mae Walker

15. Birthplace Hanover (Town, county, and state) Md.

16. Informant: Wm. Herman Schweers Father

Address 522 N. Adams St. Hanover Md.

17. Burial Date thereof: 2/16/47 (Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Hanover

18. Funeral director: Cunningham &amp; Son

Address: Hanover Md.

19. (Date rec'd by registrar) 2-14 1947 A. L. Leurs, M.D. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Hanover

City or town: Hanover (If outside city or town limits, write RURAL and give nearest town)

Street No. 522 N. Adams St (If rural, give LOCATION)

2.(a) If veteran, name war: —

## 3. (b) Social Security Number: —

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/13 1947 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/12 1947 to 2/13 1947 and that I last saw h. i. in alive on 2/13 1947

Immediate cause of death: Peritonitis + Septicemia

Due to: unknown - possible ruptured app

Due to: Ruptured app

Other conditions: —

(Include pregnancy within 8 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

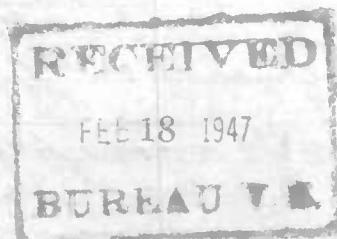
Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work? —

23. SIGNATURE: Dudley Phillips, M.D. M. D. or other

Address: Hanford Mem. Hosp. Date signed: 2/13/47

1100-10 THE UNITED STATES GOVERNMENT  
FEDERAL BUREAU OF INVESTIGATION



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

01739

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County..... *Harford*  
City or town..... *Churchville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Anna A. Scott*4. Sex *female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*B. (b) Name of husband or wife..... *Walter F. Scott*7. Birth date of deceased (mo., day, yr.) *August 7, 1866* 6. (c) If alive, give age years8. AGE: Years *60* Months *6* Days *5* If less than one day hrs. min.9. Birthplace..... *Baltimore, Md.* (Town, county, and state)10. Usual occupation..... *Housewife*

## 11. Industry or business

MOTHER FATHER 12. Name..... *Carl Pierre*13. Birthplace..... *Germany*14. Maiden name..... *Lizetta*

15. Birthplace.....

18. Informant..... *Miss Wilda Scott*Address..... *Churchville, Md.*17. Burial..... *Feb. 15, 1947* (Burial, cremation, or removal, which) Date thereof (month) (day) (year)Cemetery or crematory..... *S. P. Povatius*Location..... *Hickory, Harford Co.*18. Funeral director..... *A. R. McComas & Son,*Address..... *Abingdon, Md.*

19. Feb. 16 1947 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State..... *Md.* County..... *Harford*City or town..... *Churchville* (If outside city or town limits, write RURAL and give nearest town)Street No..... *B. Elam Road* (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *February 12 1947* at *12:55 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , to. 19. , to. 19.

and that I last saw h. alive on .

Immediate cause of death

*Cerebral Haemorrhage*

DURATION

*Momentary*Due to..... *Hypertensive Cardiovascular Dis.* 10 yrs.

Due to.....

Other conditions *Kypho-scoliosis, thoracic spine* Lifetime

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury *P. W. Rodman M.D.* Injured at work?23. SIGNATURE *P. W. Rodman M.D.*M.D. or other *P. W. Rodman M.D.*Date signed *2/14/47*

RECEIVED

FEB 20 1947

BUREAU

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01740

## CERTIFICATE OF DEATH

Reg. Dist. No.

1841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....

City or town.....

Harford  
Street Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Henrietta H. Scott

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widowed

6. (b) Name of husband or wife

Samuel L. Scott

7. Birth date of deceased (mo., day, yr.)

Oct. 1-1870

6. (c) If alive, give age years

8. AGE:

Years Months Days It less than one day

76 4 24 hrs. min.

9. Birthplace

Somerset Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

George Houethyl

13. Birthplace

Somerset Co. Md.

14. Maiden name

Julia Miles

15. Birthplace

Somerset Co. Md.

16. Informant

Mrs. Hubert Snodgrass

Address

Street, Md.

17. Burial

Date thereof Feb. 26, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Presbyterian cemetery

Location

Pocomoke City, Md.

18. Funeral director

Hubert P. Hartman

Address

Delta Pa.

19. Date rec'd by registrar

Feb. 26, 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County..... Harford

City or town..... Street, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No

## 3. (b) Social Security Number

Mo

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24,

1947 at 2<sup>30</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Saw her only on date of death Feb. 24, 1947

and that I last saw her alive on Feb. 24, 1947

Immediate cause of death Pulmonary Edema

DURATION

8 hrs.

Due to Heart failure

2 wks.

Due to Hypertensive Cardio-  
vascular disease

? -

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

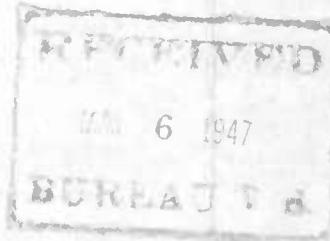
23. SIGNATURE

Charles D. Duff M.D.

M. D. or other

Address Street, Md.

Date signed 2-24-47



2-25

2-1820 — 2-10

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

01741

185-0

Reg. Dist. No.

## 1. PLACE OF DEATH:

County HARFORD

City or town HAVRE DE GRACE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 MINUTES

Hospital, institution, or street address where death occurred:

HARFORD MEMORIAL HOSPITAL

How long in hospital or institution? 10 MINUTES

## 3. (a) FULL NAME

Baby Boy Singleton

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE WHITE

8. (b) Name of husband or wife.....

6. (c) If alive, give age ..... years

7. Birth date of

deceased (mo., day, yr.) FEBRUARY 20, 1947

8. AGE:

Years

Months

Days

If less than one day hrs. 10 min.

9. Birthplace HAVRE DE GRACE HARFORD MARYLAND

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

12. Name GEORGE SINGLETON

13. Birthplace Maryland

14. Maiden name MARY SINGLETON

15. Birthplace CAVALRY MARYLAND

16. Informant

George Singleton

Address

Annapolis Md. Son. Delivery

Burial

Date thereof 2/23/47

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Angel Hill

Location

Home in Grace

18. Funeral director

Pennington &amp; Son

Address

Home in Grace Md.

19. Date rec'd by registrar

Feb. 21

19 47

(Date rec'd by registrar)

A. L. Lewis m.d.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County Harford

City or town HAVRE DE GRACE

(If outside city or town limits, write RURAL and give nearest town)

Street No. Green Del.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

2-20 1947 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-20 1947 to 2-20 1947

and that I last saw him alive on 2-20 1947

Immediate cause of death

Postpartum birth

DURATION

Due to

Early Delivery 5 1/2 months

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

E. J. Simon

Havre de Grace

M. D. or other

2-21-47

Date signed



A-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-9

## CERTIFICATE OF DEATH

01742

1820

Reg. Dist. No.

1. PLACE OF DEATH:  
County ..... Baltimore  
City or town ..... Bell Air  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 9 mos  
Hospital, institution, or street address where death occurred ..... Fountain Green Hospital  
How long in hospital or institution? ..... 9 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State ..... Md County ..... Baltimore  
City or town ..... Bell Air  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. .....  
(If rural, give LOCATION)

3. (a) FULL NAME  
Bertha Steen

3. (b) Social Security Number \_\_\_\_\_

4. Sex ..... Female 5. Color or race ..... Wk 6. (a) Single, married, widowed, or divorced ..... Singer

6. (b) Name of husband or wife ..... None

7. Birth date of deceased (mo., day, yr.) ..... April 20, 1873 8. (c) If alive, give age ..... years

8. AGE: Years ..... 73 Months ..... 9 Days ..... 19 If less than one day hrs. ..... min.

9. Birthplace ..... Pittsburgh, Pa (Town, county, and state)

10. Usual occupation ..... Retired

11. Industry or business

12. Name ..... John Steen

13. Birthplace ..... Pittsburgh, Pa

14. Maiden name ..... Mary McCormac

15. Birthplace ..... Baltimore, Md

16. Informant ..... Wm Bradford

Address ..... Bell Air, Md

17. Burial? (Burial, cremation, or removal. Which?) Date thereof ..... Mar 12/47  
(month) (day) (year)

Cemetery or crematory ..... Pittsburg, Pa

Location ..... Pittsburg, Pa

18. Funeral director ..... Dean & Foster

Address ..... Bell Air, Md

19. Date rec'd by registrar ..... 3/11/47 M.D. or other ..... Willard P. Hudson  
(Date rec'd by registrar) Address ..... Forest Hill, Md Date signed ..... Mar 10/47

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Feb 9th 1947 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28, 1946, to Feb 9th, 1947, and that last saw her alive on Feb 9, 1947.

Immediate cause of death ..... Hypostatic pneumonia DURATION 4 daysDue to ..... malnutrition DURATION 1 yrOther conditions ..... coronary myocardial disease ?

(Include pregnancy within 8 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results ..... Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of ..... Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work? ..... Address ..... Date signed ..... M.D. or other .....

23. SIGNATURE ..... Willard P. Hudson M.D. or other ..... Address ..... Forest Hill, Md Date signed ..... Mar 10/47

LETTER TO THE STATE DEPARTMENT

RECORDED MAIL

RECEIVED

MAR 12 1947

BUREAU OF

1-35





1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of error, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01744

## CERTIFICATE OF DEATH

Reg. Dist. No. 183 0

## 1. PLACE OF DEATH:

County.....

*Harford  
Upper X Roads*

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

22 yrs

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Celia Margaret Wagner.*

4. Sex

*F.*

5. Color or race

*W.*

6. (a) Single, married, widowed, or divorced

*Married*

6. (b) Name of husband or wife

*James T. Wagner*

6. (c) If alive, give age

83

years

7. Birth date of deceased (mo., day, yr.)

*June 24, 1865*

8. AGE:

Years  
*81*Months  
*7*Days  
*11*

If less than one day

hrs.

min.

9. Birthplace

*Stoney Fork, N.C.*

(Town, county, and state)

10. Usual occupation

*Housewife*

11. Industry or business

*George Watson*

12. Name

*Wilkes Co. N.C.*

13. Birthplace

*Kegiah, morphew**Ash Co. N.C.*

14. Maiden name

*James T. Wagner*

15. Birthplace

*Baldwin, Md.*

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

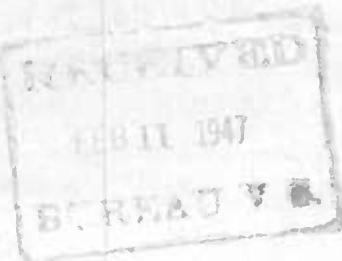
Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

01745  
1820

## APR 14 1947 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

Harford

City or town.....

Forest Hill. (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11/14. Rural. Harford Co

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

Florence Virginia Wilgis

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife.....

John W. Wilgis

7. Birth date of deceased (mo., day, yr.)

July 4 - 1854

.....(c) If alive, give age ..... years

8. AGE:

Years  
92

Months

Days

If less than one day

.....hrs. .....min.

9. Birthplace.....

Emmorton, Md

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

Charles Watters

FATHER

12. Name.....

Md

13. Birthplace

Ellen Magness

14. Maiden name.....

Md

15. Birthplace

Mr. Herman S. Wilgis

16. Informant.....

Address

Forest Hill, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Feb 15/47

Cemetery or crematory.....

Mt Zion

Location.....

Fountain Green, Md

18. Funeral director.....

Dean Foster

Address

Bel Air, Md

19. (Date rec'd by registrar)

3/14

1947

To forward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Harford

City or town.....

Forest Hill, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 13 1947 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 5 - 1947 to Feb 13 1947

and that I last saw her alive on Feb 11 1947

Immediate cause of death.....

chr myocardial Disease

terminal hypertrophic pneumonitis

Duration 3 da

Due to.....

Due to Accidental fall - fell to floor from bed

cough

Other conditions Fracture of hip

Duration 6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of January 10th, 1947

Where did injury occur? Mr. Forest Hill, Harford Maryland

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury Accidental fall

Injured at work?

23. SIGNATURE.....

Willard P. Hudson

M. D. or other

Address..... Forest Hill, Md Date signed 3/14/47

RECEIVED

FEB 18 1947

BUREAU OF INVESTIGATION

1-35-